

If you need food right away you may get CalFresh benefits within three (3) days. This is called **Expedited Service**. When you apply for CalFresh benefits, a County worker will tell you about **Expedited Service**.

To get **Expedited Service**, you must fill out an application for CalFresh which includes your Name, address and signature using one of the forms listed below:

- the SAWS 1 form, "Application for Cash Aid, CalFresh, and/or Medi-Cal/State CMSP".
- the SAWS 2 PLUS,
- CF 285 Application for CalFresh Benefits or
- Benefits CalWIN, "Application for CalFresh Benefits".

You will get an interview for Expedited Services CalFresh if you answer "yes" to any of the three questions below:

- Your monthly income is less than \$150 **-and-** you have \$100 or less in cash
- Your housing costs (rent/mortgage and utilities) are more than your monthly income and cash
- You are a migrant or seasonal farm worker **-and-** have \$100 or less in cash

Special Note: For Homeless Applicants: Homeless applicants should advise clerical that they are "Homeless" when turning in the application.

*Have you applied for or are you receiving Tribal TANF? YES ___ NO ☒

SC 239.2 (Revised 9/2016)

<i>Horton</i>		<i>James E</i>		<i>08/11/1970</i>		<i>274-84-5382</i>	
<input checked="" type="checkbox"/> Male	Other Name Used (i.e. Maiden Name, etc.)			Place of Birth		Marital Status:	
<input type="checkbox"/> Female	<i>Jacob</i>			<i>Sewickley, PA</i>		<input type="checkbox"/> Married <input checked="" type="checkbox"/> Single	
US Citizen?		If no, date of entry		Requesting Aid		Migrant or Seasonal Farm Worker?	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		into U.S. _____		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
CIN #				CWIN #			

2. Please Fill In Information About Your **SPOUSE/OTHER ADULT (Parent of Minor Children) LIVING WITH YOU:**

Last Name		First Name		Middle Initial		Date of Birth		Social Security Number	
<input type="checkbox"/> Male	Other Name Used (i.e. Maiden Name)			Place of Birth		Marital Status:		<input type="checkbox"/> Single	
<input type="checkbox"/> Female						<input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Widow	
US Citizen?		If no, date of entry		Requesting Aid		Applicant Alien "A" No. (if applicable)		Migrant or Seasonal Farm Worker?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		into US _____		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Relationship to applicant:				CIN #				CWIN #	

Continue on other side

Please answer all questions

Today's Date: 10-29-2020Program(s) you are applying for: ☐ CalWORKs ☐ General Assistance ☐ CalFresh ☐ Health Coverage ☐ RCA ☐ CAPI

Applicant Questions – Answer all questions	Clerical Instructions
Have you served or are you a dependent of someone who served in the military? <input checked="" type="checkbox"/> Yes or <input type="checkbox"/> No	<input type="checkbox"/> CW5 issued with bureau code written in Bureau Code section. Ask customer to complete and return form to designated drop box or window. <input type="checkbox"/> N/A
Were you in Foster Care on your 18 th birthday? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No	If yes, give customer MC 250A. Do not give packet.
Have you applied for Health Coverage through Covered California? <input type="checkbox"/> Yes or <input checked="" type="checkbox"/> No	If yes, check External Referral Window in CalWIN for application and follow CP030.
Have you had recent changes in your life that made you want to apply for health insurance? If yes, check all that apply <input type="checkbox"/> Adoption <input type="checkbox"/> Birth of family member <input type="checkbox"/> Death of family member <input type="checkbox"/> Divorced <input type="checkbox"/> Incarceration Status Change <input type="checkbox"/> Lost job <input type="checkbox"/> Married <input type="checkbox"/> Moved into the State/County <input type="checkbox"/> New Hire When did this life event occur?	Answer questions regarding Life Event on Collect Applicant Information Window in CalWIN

1. Applicant Information

Applicant's Last Name	First Name	Middle Initial	Date of Birth	Social Security Number
<u>Horton</u>	<u>James</u>	<u>E</u>	<u>08/11/1976</u>	<u>274-84-5382</u>
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Other Name Used (i.e. Maiden Name, etc.) <u>Jacob</u>		Place of Birth <u>Sewickley, PA</u>	Marital Status: <input type="checkbox"/> Married <input checked="" type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
US Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If no, date of entry into U.S. _____	Requesting Aid <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant Alien "A" No. (if applicable)	Migrant or Seasonal Farm Worker? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
County use only			County use only	
CIN #			CWIN #	

2. Please Fill In Information About Your SPOUSE/OTHER ADULT (Parent of Minor Children) LIVING WITH YOU:

Last Name	First Name	Middle Initial	Date of Birth	Social Security Number
<input type="checkbox"/> Male <input type="checkbox"/> Female	Other Name Used (i.e. Maiden Name)		Place of Birth	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow
US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, date of entry into US _____	Requesting Aid <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant Alien "A" No. (if applicable)	Migrant or Seasonal Farm Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to applicant:			County use only	County use only
CIN #			CWIN #	

Continue on other side

3. Do you prefer your forms in English? ☒ Yes ☐ No If No, please specify language _____
4. Do you need an interpreter? ☐ Yes ☒ No If Yes, please specify language _____
5. How long have you lived in Sacramento County? Date arrived: November 2012
6. Home address Indigent City Sacramento Zip 95822
7. Home Phone# 916-562-5584 Message Phone # _____
8. Are you pregnant?: ☐ Yes ☒ No How Many Months? _____ Due Date: Mo: _____ Yr: _____
9. List all other people (including children) who live with you: N/A

Name (Last, First & MI) include unborn	S E X	DOB	Social Security Number	Requesting Aid? Circle One	Relation To Applicant	US Citizen	County Use Only CIN #	County Use Only CWIN #
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> M <input type="checkbox"/> F			Yes No		<input type="checkbox"/> Y <input type="checkbox"/> N		

COUNTY USE ONLY

Clearance Data

Program(s) App Reg'd: ☐ CalWORKs ☐ General Assistance ☐ CalFresh ☐ Medi-Cal ☐ RCA ☐ CMISP ☐ CAPI

Archive Data Retrieved by: _____

CalWIN Completed by: _____

MEDS Completed by: _____

Appt. Time: _____

Appt. Date: _____

Appt. Location: _____

Medi-Cal Mail In Due Date: _____

Application #: _____

Case Name: _____

Case Serial #: _____

Case Load #: _____

CMISP Medical Record# _____

AS400 Completed by _____

Courtesy Application scanned by _____

on _____

Comments:

Case Number: _____
 Date: _____
 Case Name: _____
 Worker Name: _____
 Worker Phone Number: _____
 Worker Number: _____

LANGUAGE PREFERENCE AND ASSISTED LISTENING and READING IDENTIFICATION

County Use Only: ☐ Intake/Recertification ☐ Substantive/Significant Contact

Please read, complete and mark the box(es) that apply to you to acknowledge that you have been informed and understand the following:

- ☒ My primary language is English and/or my culture is heterogeneously American.
- ☐ Yes, I wish to receive written communications and forms in my primary language if translations have been made by the California Department of Social Services or by Sacramento County Department of Human Assistance.
- ☒ No, I do not wish to receive this service.
- ☐ Yes, I wish to have a worker who is familiar with _____ language and/or _____ culture.
- ☒ No, I do not wish to have this service.
- ☐ Yes, I understand that I can request and receive free interpreter services from the county if a worker for my language is not available and I understand I am not required to provide my own interpreter.
- ☐ Yes, I wish to have an interpreter if a worker for my language is not available.
- ☒ No, I do not wish to have this service.
- ☐ Yes, I understand that I can use my own interpreter; however, there may be potential problems of ineffective communication if using my own interpreter.
- ☐ Yes, I wish to use _____ as my own interpreter.
- _____ Name of Interpreter
- ☐ Yes, the county has informed me that they cannot use anyone under 18 as an interpreter except under emergency circumstances. This may include medical emergency, determining language need, or if no other source is available.
- ☐ Yes, I authorize the County to release my case information to the interpreter.
- ☒ No, I do not authorize the County to release my case information to the interpreter.
- ☐ Yes, I wish to receive hearing or visual aids such as Telecommunication Device for the Deaf (TDD), Large Print Forms, audio tapes, CDs, Braille, etc., if available. Items or services requested: _____
- ☒ No, I do not wish to receive this service

Interpreter service provided by:

- ☐ Friend/Family member ☐ Contracted interpreter
☐ Telephone interpreter ☐ County Employee

Interpreter Name: _____ Signature: _____ Date: _____

Applicant/Recipient Name: _____ Signature: _____ Date: _____

County Use Section: County Employee, Contracted or Telephone Interpreter

Name of company providing service on site/telephone: _____

Interpreter Name: _____ Signature: _____ Date: _____

Worker Name _____ Worker Code _____ Date _____
 (required)



SAVE

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Check One)

- ☐ Already registered. I am registered to vote at my current residence address.
- ☐ Yes. I would like to register to vote. (Please fill out the attached voter registration form.)
- ☒ No. I do not want to register to vote.

NOTE: IF YOU DO NOT CHECK A BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. YOU MAY TAKE THE ATTACHED VOTER REGISTRATION FORM TO REGISTER AT YOUR CONVENIENCE.

James E. Horton James E. Horton 10 29 2020
Applicant Name Date

Important Notices

1. Applying to register or declining to register to vote will **not** affect the amount of assistance that you will be provided by this agency.
2. If you would like help in filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.
3. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party preference or other political preference, you may file a complaint with the Secretary of State by calling toll-free (800) 345-VOTE (8683) or you may write to: Secretary of State, 1500 - 11th Street, Sacramento, CA, 95814. For more information on elections and voting, please visit the Secretary of State's website at www.sos.ca.gov.

See Youtube
Channel (again) →
saakshis
↓
Google account

Fill out this section to report reduced work or training hours for Able-Bodied Adults without Dependents (ABAWDs). (ABAWDs are adults between 19 and 50 who are not caring for minor children.)

The number of hours worked or in training dropped below 20 hours a week or 80 hours a month to _____ hours per week or _____ hours per month.

Name of person(s)

Relationship to you

Explain what happened

Date of change

hours a week or 80 hours a month

I have kept records, thus a constant evidence to show my personal property over the duration of last two (6 months) periods, I have procured by process of abuse of delays by procurement of DHS. It is a 50-called ombudsman Sarah Russo was personally hostile while being harassed administratively. Enemies all mine, one of the persons organized about my income, property, or family may be charged with committing a felony

I would like to report the following information:

My living cost resources is procured from exchange of CRV materials. I amounts to approximately \$20 per week, or \$90 per month. I have also received free-will alms this period amounting to approximately \$2 per day. Record keeping of these sources is impracticable -- neither provides receipts. These above entail totality of my income. All-though approximated, this income is certainly within the poverty range on scale for eligibility.

Resulting in such means has resulted from: 1. Blacklisting from employment (otherwise) affected by Government Misconduct in Conspiracy to Commit Violations of the Constitution..., 2. its Damages Caused with Malice Intent circumstantially causing my status of Indigency.

Therefore, prejudicial and malicious, procedural bastunation ^{to by abuse of power} more egregious to intend; -- P.S.: Casework of relevant matters ^{in progress} addressed is majorly component to my actual vocations (exceptional). Agreement for ^{revenue funds...} I need to eat also!

I UNDERSTAND THAT: If on purpose I do not report all facts or give wrong facts about my income, property, or family status to get or keep getting aid or benefits, I can be charged with a crime. And, I may be charged with committing a felony if more than \$950 in cash aid and/or CalFresh is wrongly paid out.

I declare under penalty of perjury under the laws of the United States and the State of California that the facts contained in this report are true and correct and complete.

WHO MUST SIGN BELOW:

For Cash Aid: you and your aided spouse, Registered Domestic Partner, or the other parent (of cash aided children), if living in the home.

For CalFresh: the head of household, household member or the household's authorized representative.

Signature or Mark

Date Signed _____

Home Phone

Contact Phone

Signature of Spouse, Registered Domestic Partner
or other Parent of Cash Aided Children

Date Signed _____

Signature of Witness to Mark, interpreter or other person completing form

Date Signed _____

MID-PERIOD STATUS REPORT**For Cash Aid and CalFresh**

RECIPIENT'S NAME: _____

CASE NUMBER (IF KNOWN): _____

Use this form to report mandatory or voluntary changes that have occurred since you last reported.

If you are reporting income information, please provide proof, such as: pay stubs; copies of checks; letters from agencies; etc. If you're having problems getting the proof and need help, call the county.

If you are reporting changes in expenses, please provide proof, such as: receipts; canceled checks; paid invoices; etc. If you're having problems getting the proof and need help, call the county.

If you are reporting an address change, please provide proof of expenses such as: a copy of your new rental agreement or lease; rent receipt for your new address; copies of utility deposits; etc.

MANDATORY INFORMATION

If you get Cash Aid, report the information marked CA. If you get CalFresh, report the information marked CF. Sections marked CA/CF are for all households/assistance units.

CA/CF ☐ My combined household income is more than the limit for my household size.
In the month of _____, the total combined income for my household is \$ _____.

CA ☐ Someone in my household is hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime.
Name of person _____

CA ☐ Someone in my household has been found by a court of law to be in violation of probation or parole.
Name of person _____

CA ☐ I have moved, changed my phone number or have a new mailing address.
New home address _____

New mailing address (if different from your home address) _____

New phone number (_____) _____

- ☐ I get free rent at this new address.
☐ My rent amount is \$ _____ per month.
☐ I share the rent, my share is \$ _____.
☐ I became homeless.

- ☐ I get free utilities at this new address.
☐ My utilities are \$ _____ per month.
I have: ☐ Heating ☐ Cooling
☐ Water ☐ Sewer
☐ Garbage ☐ Telephone
☐ Other

See other side

Please use black or blue ink because it is easy to read and copies best. Please print your answers.

If you need more space to answer a question(s), attach additional sheets of paper to provide the information. Please be sure to identify which question you are writing about on the additional sheets of paper.



1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST) James E. Horton		OTHER NAMES (MAIDEN, NICKNAMES, ETC.) Jacob		SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS) 214-84-5382	
HOME ADDRESS OR DIRECTIONS TO YOUR HOME Indigent	APARTMENT # N/A	CITY Sacramento	COUNTY Sacramento	STATE CA	ZIP CODE 95822
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	COUNTY	STATE	ZIP CODE

I want to get information about this application by email. ☐ Yes ☐ No

HOME PHONE **N/A** WORK/ALTERNATE/MESSAGE PHONE **N/A** EMAIL ADDRESS **jacob.horton@gmail.com**

What programs are you applying for?
☒ CalFresh ☐ Cash Aid ☐ Health Coverage

Do you have a disability and need help applying? ☐ Yes ☒ No

Are you homeless? ☒ Yes ☐ No If yes, please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.

What language do you prefer to read (if not English)? **N/A**

What language do you prefer to speak (if not English)? **N/A**

The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here ☐

<input checked="" type="checkbox"/> Is your household's gross income less than \$150 and cash on hand, checking and savings accounts of \$100 or less?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Have your utilities been shut off or do you have a shut-off notice?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Will your food run out in 3 days or less?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Is your household a migrant/seasonal farm worker household with liquid resources not exceeding \$100?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Do you need help with transportation to get food, clothing, medical care or other emergency item(s)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Do you have an eviction notice or a notice to pay rent or leave?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Do you need essential clothing, such as diapers or clothing needed for cold weather?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is anyone pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, did she get a Presumptive Eligibility card? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does anyone in your household have a personal emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check box: <input type="checkbox"/> Pregnancy <input type="checkbox"/> Immediate Medical Need <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Other emergency which threatens health or safety. Explain:			

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- My answers to the questions are true and complete to the best of my knowledge.
- Any answers I may give for my application process will be true and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1).
- I read, or had read to me, the Program Rules and Penalties (Program Rules Pages 2 - 4).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits and cash aid.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.
- I am giving the Medi-Cal agency the right to pursue and get any money from other health insurance, legal settlements or other third parties.

SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE (GUARDIAN))
James E. Horton

DATE
10/19/2020

SIGNATURE OF SPOUSE, OTHER PARENT, AIDED ADULT, OR REGISTERED DOMESTIC PARTNER

DATE

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years of age or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? ☐ Yes ☒ No
If **yes**, complete the following section:

AUTHORIZED REPRESENTATIVE NAME

AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh Benefits for your household? ☐ Yes ☐ No
If **yes**, complete the following section:

NAME

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP CODE

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES

You can give a trusted person permission to talk about your application for health insurance, see your information and act for you on things about this part of your application. Do you want to choose an authorized representative for the health insurance part of your application? ☐ Yes ☒ No If **yes**, fill out the information in Appendix C (on the SAWS 2 PLUS).

3. Are you or any member of your family American Indian or Alaskan Native? ☐ Yes ☒ No
If **yes**, and applying for health care, please go to Appendix B (on the SAWS 2 PLUS) for additional questions.

RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☒ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY

ARE YOU OF HISPANIC, LATINO OR SPANISH ORIGIN?

☐ Yes ☒ No

IF YOU ARE OF HISPANIC OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF:

☐ Mexican ☒ Puerto Rican ☐ Cuban ☐ Other

RACE/ETHNIC ORIGIN

☒ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed

☐ Asian (If checked, please select one or more of the following):

☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian

☐ Other Asian (specify)

☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian

☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You will need to have an interview with the County to discuss your application and to receive cash aid or CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in-person or would prefer an in-person interview. Cash aid applicants must have an in person interview. If you are applying for CalWORKs and CalFresh, your CalFresh interview will be done at the same time as your CalWORKs interview during normal office hours.

☐ Please check this box if you would prefer an in-person interview for CalFresh.

☐ Please check this box if you need other arrangements due to a disability.

5. OTHER PROGRAMS

Has anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Tribal TANF, Medicaid, Supplemental Nutrition Assistance Program [food stamps], General Assistance/General Relief, etc.)? ☒ Yes ☐ No

IF YES, WHO?

Myself, James E. Horton

WHERE (COUNTY/STATE)?

Sacramento / CA

IF YES, WHO?

WHERE (COUNTY/STATE)?

DEMOGRAPHIC QUESTIONNAIRE FOR CALWORKS, REFUGEE CASH ASSISTANCE (RCA), ENTRANCE CASH ASSISTANCE (ECA), TRAFFICKING AND CRIME VICTIMS ASSISTANCE PROGRAM (TCVAP) AND CALFRESH PROGRAMS

Legal Name:

James E. Horton (by birth on record)

Case Number:

(Optional) Preferred Name and Pronoun(s):

Jacob (Not determined as yet for Record of Name Change)

The following personal information is optional and confidential. It is asked to make sure that benefits are given without regard to sexual orientation or gender identity. Your answers will not affect your eligibility or benefit amount. The law says the county must ask your sexual orientation and gender identity, but you are not required to answer. Your name and case number are only used to be sure the county asked you the questions. The county will only use this information for civil rights statistical purposes. You can ask the county for another form to change your responses at any time.

- ☐ Check this box if you do not want to give the county information about your sexual orientation or gender identity. You can also select "decline to state" on each of the questions below.

1. **OPTIONAL:** What is your gender identity? Please check one that best describes your gender identity:

- ☐ Female (assigned female at birth and identify as female)
☒ Male (assigned male at birth and identify as male)
☐ Transgender female (assigned male at birth and identify as female)
☐ Transgender male (assigned female at birth and identify as male)
☐ Non-binary (neither, both or a combination of male or female)
☐ Another gender identity *Not a Purnball Freak*
☐ Decline to state

2. **OPTIONAL:** What sex was listed on your original birth certificate? Please check one:

- ☐ Female ☒ Male ☐ Decline to state

3. **OPTIONAL:** What is your sexual orientation? Please check one that best describes your sexual orientation: *This is inappropriately worded*

- ☐ Straight or heterosexual (attracted to people with the opposite gender)
☐ Gay or lesbian (attracted to people with the same gender)
☐ Bisexual (attracted to people with both the same and different genders)
☒ Queer (do not identify with straight/heterosexual, gay/lesbian or bisexual)
☒ Another sexual orientation *(Celibate) (Regenerate in Jesus Christ)*
☐ Unknown
☐ Decline to state

Case Number: _____
Date: _____
Case Name: _____
Worker Name: _____
Worker Phone Number: _____
Worker Number: _____

TEXT MESSAGING AND EMAIL NOTIFICATION SERVICE AGREEMENT

Would you like to receive text message and/or email reminders from the Sacramento County Department of Human Assistance (DHA) about your benefits? DHA is offering a reminder service for several programs by email and/or text message to your cell phone. This service is optional. You will continue to receive notices by mail whether or not you choose to receive text messages and/or email reminders.

These messages are not confidential. Anyone who uses your cell phone or email or who has access to them might see the text messages/emails. Communication service providers used by you or DHA may also be able to see these messages. Text message charges may apply depending on your text message plan. DHA is not responsible for charges you may accrue by accepting DHA's text messages. Therefore, DHA will not send you text messages or emails without your permission.

By signing this Text Messaging and Email Notification Service Agreement, you are authorizing DHA to send you text messages and/or emails about appointments, renewals, and other information about your case. You may stop this service by calling (916) 874-3100 or (209) 744-0499 (for those in the 209 area code). TDD/TTY, Hearing Impaired may call (916) 874-2599. If you stop these services, you will still be sent mailed notices.

If your cell phone number/email address changes or your phone is lost, please contact a worker.

Please complete the information below (and return in the attached envelope if not completing in person).

I understand that this service is optional and I can stop participating at any time, and that I should not reply to the messages as responses are not monitored.

I would like to receive text messages from DHA.

☒ YES

☐ NO

I would like to receive email messages from DHA.

☒ YES

☐ NO

Printed Name

James E. Horton

274-84-5382

Social Security Number

Date of Birth

08/11/1970

1B4TN39

Case Number

Signature

James E. Horton

10292020

Date

Cell Phone Number

(916) 562-5584

jaakovos@gmail.com

Email Address



SAC 1022_34F

Please use black or blue ink because it is easy to read and copies best. Please print your answers. If you need more space to answer a question(s), attach additional sheets of paper to provide the information. Please be sure to identify which question you are writing about on the additional sheets of paper.

1. APPLICANT'S INFORMATION

NAME (FIRST, MIDDLE, LAST) <u>James E. Horton</u>		OTHER NAMES (MAIDEN, NICKNAMES, ETC.) <u>Jacob</u>		SOCIAL SECURITY NUMBER (IF YOU HAVE ONE AND ARE APPLYING FOR BENEFITS) <u>274-84-5382</u>	
HOME ADDRESS OR DIRECTIONS TO YOUR HOME <u>Indigent</u>		APARTMENT #	CITY	COUNTY	STATE ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE) <u>Indigent</u>		APARTMENT #	CITY	COUNTY	STATE ZIP CODE
I want to get information about this application by email. <input type="checkbox"/> Yes <input type="checkbox"/> No			I want to get messages about my case by email. <input type="checkbox"/> Yes <input type="checkbox"/> No		
HOME PHONE <u>916-562-5584</u>		WORK/ALTERNATE/MESSAGE PHONE <u>N/A</u>		EMAIL ADDRESS <u>saakovos@gmail.com</u>	
What programs are you applying for? <input checked="" type="checkbox"/> CalFresh <input type="checkbox"/> Cash Aid <input type="checkbox"/> Health Coverage <input type="checkbox"/> Other			Do you have a disability and need help applying? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Are you homeless? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please let the County know right away if you are homeless, so they can help you figure out an address to use to accept your application and get notices from the county about your case.					
What language do you prefer to read (if not English)? <u>English</u>					
What language do you prefer to speak (if not English)? <u>(N/A)</u>					
The County will provide an interpreter at no cost to you. If you are deaf or hard of hearing please check here <input type="checkbox"/>					
Is your household's gross income less than \$150 and cash on hand, checking and savings accounts \$100 or less?		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Have your utilities been shut off or do you have a shut-off notice? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Will your food run out in 3 days or less? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Is your household a migrant/seasonal farm worker household with liquid resources not exceeding \$100?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Do you need help with transportation to get food, clothing, medical care or other emergency item(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Do you have an eviction notice or a notice to pay rent or leave?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Do you need essential clothing, such as diapers or clothing needed for cold weather? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is anyone pregnant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, did she get a Presumptive Eligibility card? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Does anyone in your household have a personal emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check box: <input type="checkbox"/> Pregnancy <input type="checkbox"/> Immediate Medical Need <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Other emergency which threatens health or safety. Explain:					

I understand that by signing this application under penalty of perjury (making false statements), that:

- I read, or had read to me, the information in this application and my answers to the questions in this application.
- Any answers I have given on pages 1 through 17 and appendices A through E of the SAWS 2 Plus are true, correct, and complete to the best of my knowledge.
- I read or had read to me and I understand and agree to the Rights and Responsibilities (Program Rules Page 1).
- I read, or had read to me, the Program Rules and Penalties (Program Rules Pages 2 - 4).
- I understand that giving false or misleading statements or misrepresenting, hiding or withholding facts to establish eligibility is fraud and that I may be subject to penalties under federal law if I provide false or untrue information. Fraud can cause a criminal case to be filed against me and/or I may be barred for a period of time (or life) from getting CalFresh benefits and cash aid.
- I understand that Social Security Numbers or Immigration Status for household members applying for benefits may be shared with the appropriate government agencies as required by federal law.
- I am giving the Medi-Cal agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties.

SIGNATURE OF APPLICANT, CARETAKER RELATIVE (OR ADULT HOUSEHOLD MEMBER/ AUTHORIZED REPRESENTATIVE/GUARDIAN)
*If you have an Authorized Representative, please complete Question 2 on the next page.

SIGNATURE OF SPOUSE, OTHER PARENT, OTHER AIDED ADULT, OR REGISTERED DOMESTIC PARTNER

DATE

DATE

2. HOUSEHOLD'S AUTHORIZED REPRESENTATIVE

You may authorize someone 18 years or older to help your household with your CalFresh benefits. This person can also speak for you at the interview, help you complete forms, shop for you, and report changes for you. You will have to repay any benefits you may get by mistake because of information this person gives the County and any benefits you didn't want them to spend will not be replaced. If you are an Authorized Representative you will need to give the County proof of identity for yourself and the applicant.

Do you want to name someone to help you with your CalFresh case? ☐ Yes ☒ No

If yes, complete the following section:

AUTHORIZED REPRESENTATIVE NAME

AUTHORIZED REPRESENTATIVE PHONE NUMBER

Do you want to name someone to receive and spend CalFresh Benefits for your household? ☐ Yes ☐ No

If yes, complete the following section:

NAME

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP CODE

2a. HEALTH INSURANCE AUTHORIZED REPRESENTATIVES

You can give a trusted person permission to talk about your application for health insurance, see your information, and act for you on things about this part of your application. Do you want to choose an authorized representative for the health insurance part of your application? ☐ Yes ☒ No If yes, fill out the information in Appendix C.

3. Are you or any member of your family American Indian or Alaskan Native? ☐ Yes ☒ No

If yes, and applying for health care, please go to Appendix B for additional questions.

RACE/ETHNICITY

Race and ethnicity information is optional. It is requested to assure that benefits are given without regard to race, color, or national origin. Your answers will not affect your eligibility or benefit amount. Check all that apply to you. The law says the County must record your ethnic group and race.

☒ Check this box if you do not want to give the County information about your race and ethnicity. If you do not, the County will enter this information for civil rights statistics only.

ETHNICITY ARE YOU OF HISPANIC, LATINO, OR SPANISH ORIGIN? ☐ Yes ☒ No IF YOU ARE OF HISPANIC, OR LATINO ORIGIN, DO YOU CONSIDER YOURSELF ☐ Mexican ☐ Puerto Rican ☐ Cuban ☒ Other

RACE/ETHNIC ORIGIN

☒ White ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Other or Mixed
☐ Asian (If checked, please select one or more of the following):
☐ Filipino ☐ Chinese ☐ Japanese ☐ Cambodian ☐ Korean ☐ Vietnamese ☐ Asian Indian ☐ Laotian
☐ Other Asian (specify) _____
☐ Native Hawaiian or Other Pacific Islander (If checked, please select one or more of the following): ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan

4. INTERVIEW PREFERENCE

You will need to have an interview with the County to discuss your application and to receive cash aid or CalFresh benefits. Interviews for CalFresh are usually done by phone, unless you can be interviewed when giving your application to the County in person or would prefer an in-person interview. Cash aid applicants must have an in person interview. If you are applying for CalWORKs and CalFresh, your CalFresh interview will be done at the same time as your CalWORKs interview during normal office hours.

☐ Please check this box if you would prefer an in-person interview for CalFresh.

☐ Please check this box if you need other arrangements due to a disability.

5. OTHER PROGRAMS

Has anyone in your household ever received public assistance (Temporary Assistance for Needy Families, Tribal TANF, Medicaid, Supplemental Nutrition Assistance Program [food stamps], General Assistance/General Relief, etc.)? ☒ Yes ☐ No

IF YES, WHO?

James E. Horton

WHERE (COUNTY/STATE)?

Sacramento, CA

IF YES, WHO?

WHERE (COUNTY/STATE)?

6. HOUSEHOLD'S INFORMATION: ADULTS

Complete the following information for all adults in the home. If applying for health care coverage, also include any adults claimed on your tax return.

If you are applying for cash aid and there is more than one adult in the home who is applying for cash aid or who is the parent of a child applying for aid, please go to Appendix D for additional questions.

For noncitizens you are applying for, please complete additional questions 6e and 6f.

APPLYING FOR BENEFITS (check each type)		NAME (Last, First, Middle Initial)	How is the person related to you?	DATE OF BIRTH (M OR F)	Marital Status					Disabled (check if yes)	Full-Time Student (check if yes)	Only answer the question below for each person applying for benefits.	U.S. CITIZEN or NATIONAL (check Yes or No) If no, complete question 6e.	SOCIAL SECURITY NUMBER
None	*Cash Aid				Medi-Cal Health Care	CalFresh	Single	Married	Separated					
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Horton, James, E.	Myself	08/11/70	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	974-84-5382	
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

* Cash Aid also includes General Assistance and General Relief programs.

6a. Does everyone listed in question 6 have the same contact information? ☒ Yes ☐ No If no, please fill in the person's contact information below.

NAME (FIRST, MIDDLE, AND LAST)	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
	EMAIL ADDRESS (OPTIONAL)				
	HOME (STREET) ADDRESS	APARTMENT #	CITY	STATE	ZIP CODE
	MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APARTMENT #	CITY	STATE	ZIP CODE
	EMAIL ADDRESS (OPTIONAL)				



6d. Has anyone been in the U.S. Military service or are they the spouse, parent or child of a person who was? ☒ Yes ☐ No

If yes, please complete the information below. If no, please continue to the next question.

Name	U.S. Citizen?	(✓) Status	Honorable Discharge?	Dates of Service
James E. Horton	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active duty <input checked="" type="checkbox"/> Veteran <input type="checkbox"/> Spouse, parent, or child of person in active duty or a veteran	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2005 - 2012
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active duty <input type="checkbox"/> Veteran <input type="checkbox"/> Spouse, parent, or child of person in active duty or a veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No	



6e. NONCITIZEN INFORMATION - Please complete for noncitizens you are applying for.

Name	Date entered U.S. (if known)	Does this person have an eligible immigration status? If yes, please provide their immigration document and number.	Has this person lived in the U.S. continuously since 1996?	Is this person a Naturalized Citizen?	Sponsored? (check Yes or No) If yes, complete question 6f
		DOCUMENT TYPE: DOCUMENT NUMBER:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DOCUMENT TYPE: DOCUMENT NUMBER:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DOCUMENT TYPE: DOCUMENT NUMBER:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does anyone listed above have at least 10 years (40 quarters) of work history?

☒ Yes ☐ No

If yes, who? Myself, James E. Horton

Does anyone listed above have, or have they applied for, or do they plan to apply for a T-Visa or U-Visa, VAWA petition?

☐ Yes ☒ No

If yes, who? N/A

☐ Yes ☒ No

Has anyone changed their immigration status in the last 12 months?

If yes, please complete the information below.

If no, please continue to the next question.

NAME	WHAT CHANGED?	DATE OF CHANGE	ALIEN NUMBER (IF APPLICABLE)
	<u>N/A</u>		

6p. Is there a foster child currently living in your home who is receiving foster care services? ☐ Yes ☒ No

If yes, who?

Please answer the following questions about the foster child(ren):

Was this child(ren) placed in your home under a dependency order of the court?

Do you want the foster care child(ren) counted in your CalFresh case?

If yes, the foster care income you receive will be counted as unearned income.

If no, the foster care income will not be counted as unearned income.

6q. Does everyone listed in question 6 live in California and expect to keep living here? ☐ Yes ☒ No

If no, please explain.

Legal
business matters

I have matters restricting to move
region: not even, really, my
residence. concluded.

6r. Does anyone listed in question 6 plan to leave California for more than 30 days? ☐ Yes ☒ No

If yes, please explain.

Not this benefit period (6 months)

NAME

WHEN DO THEY PLAN TO LEAVE?

DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA?

☐ YES ☐ NO IF YES, WHEN:

NAME

WHEN DO THEY PLAN TO LEAVE?

DOES THIS PERSON PLAN TO RETURN TO CALIFORNIA?

☐ YES ☐ NO IF YES, WHEN:

7. Unearned Income

Does anyone get income that does not come from work (unearned)? ☐ Yes ☐ No If yes, please answer this question.

If no, skip to the next question.

Check all types of unearned income that apply from these examples (there may be others not listed here):

- ☐ Social Security Disability
- ☐ SSI/SSP
- ☐ Cash aid
- ☐ CalWORKs/TANF/GA/GR/CAPI/RCA
- ☐ Room and board (from a renter)
- ☐ Pension
- ☐ Child/Spousal support
- ☐ Rental/Royalties
- ☐ Social Security retirement or survivors benefits
- ☐ Per capita payments
- ☐ Work study/welfare to work or other program

- ☐ Sales of notes, contracts, trust deeds, promissory notes
- ☐ Veterans education benefits/income
- ☐ Government/railroad disability or retirement
- ☐ Veteran benefits or Military pension
- ☒ Financial aid (school grants/loans/scholarships)
- ☐ Gifts of money or other loans
- ☐ Unemployment Insurance/State Disability Insurance (SDI)
- ☐ Worker's Compensation
- ☐ Net Farming/Fishing

- ☐ Lottery/gambling winnings
- ☐ Help with rent/food/clothing
- ☐ Insurance or legal settlements
- ☐ Private disability or retirement
- ☐ Dividend and interest income
- ☐ Strike benefits
- ☐ Other

Person Getting the Money?	From Where?	How Much?	How Often Received? (once, weekly, monthly, or other)	Expect to Continue? (Check Yes or No)
Myself, James E. Horton	Free-will gifts offered.	Varies by minimal	Spontaneously and varied.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

If this income is not expected to continue, please explain:

I cannot rely on spontaneous, free-will gifts (alms).
Unfixed and not guaranteed.



8. Earned income

Does anyone get income from a job (earned income)? ☒ Yes ☒ No If yes, please answer this question.
If no, skip to the next question.

NOTE: If self-employed, fill out question 8a below.

Please list all income **before** taxes or other deductions are taken out (gross income).

Examples of earned income are (these examples can be full-time, temporary seasonal work, or training, and there may be others not listed here):

- Wages
- Commissions
- Tips
- Salaries
- Work study (students)
- Include any paid jobs the County helped you get.

Person Working	Employer's Name and Address	Employer's Phone Number	Hourly Rate	Average hours per week	How Often Paid? (Once weekly, monthly, other)	Total Gross Earned Income Received This Month?	Expect to Continue? (✓ Check Yes or No)
James E. Horton	Portable with address with mobile property	916-562-5584	\$ N/A	All not sleeping 24	Varies: flexible to decisions exchanged	\$ 40 so far	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

If this income is not expected to continue, please explain:

? Recycle Business policy during time of disorder and instability? → Recent Events



Has anyone lost a job, changed jobs, quit a job, or reduced work hours within the last 60 days? ☐ Yes ☒ No

In the last year? ☐ Yes ☒ No

Did the County help the person get this job? ☒ Yes ☐ No

IF YES, WHO?

DATE OF JOB LOSS, QUIT, OR CHANGE

DATE OF LAST PAY

REASON?

IS ANYONE ON STRIKE?

IF YES, WHO?

DATE WENT ON STRIKE

DATE OF LAST PAY

REASON?

☐ Yes, ☐ No



8a. Self-Employment

Self-employed household members may take actual self-employment expenses (or for CalFresh or cash aid, take a standard 40% deduction off of self-employment income). For cash aid, you may also choose to use a monthly average (yearly business costs divided by 12 months). If you choose actual expenses, you must list your business expenses on a separate sheet of paper.

Person Self-Employed	Business Name	Type of Business	Date Business Started	Gross Monthly Income	Self-Employment Expenses (please ✓ check one)	*Net Monthly Income
Myself James E. Horton	Not really a business per se, yet a vocation and occupation.	Other than Business	08/11/1970	\$	<input type="checkbox"/> 40% flat Rate (CalFresh/cash aid) <input type="checkbox"/> Actual Expenses \$ _____ <input type="checkbox"/> Monthly Average \$ _____	\$
				\$	<input type="checkbox"/> 40% flat Rate (CalFresh/cash aid) <input type="checkbox"/> Actual Expenses \$ _____ <input type="checkbox"/> Monthly Average \$ _____	\$
				\$	<input type="checkbox"/> 40% flat Rate (CalFresh/cash aid) <input type="checkbox"/> Actual Expenses \$ _____ <input type="checkbox"/> Monthly Average \$ _____	\$

* Net monthly income is gross monthly income minus expenses.



9. Other Income



Does anyone get housing or rent, utilities, food or clothing free or in exchange for work? ☐ Yes ☒ No
If **yes**, please answer this question.
If **no**, skip to the next question.

Item Received	Free	For Work	Who gets the item?	Value	Who gives the item?
Housing or Rent	<input type="checkbox"/>	<input type="checkbox"/>		\$	
Utilities	<input type="checkbox"/>	<input type="checkbox"/>		\$	
Food	<input type="checkbox"/>	<input type="checkbox"/>		\$	
Clothing	<input type="checkbox"/>	<input type="checkbox"/>		\$	



10. Yearly Income

Does anyone's total income (unearned, earned, and self employment) change from month to month? ☒ Yes ☐ No
If **yes**, please answer this question.
If **no**, skip to the next question.

Name of Person	What will be their total income this year?	What will be their total income next year (if you think it will be different)?
James E. Horton	\$ Same	According to Lord's Will and can't foresee
	\$	\$



11. Household's Child/Adult Care Expenses (The actual amount of cost incurred if allowing the expenses to potentially be a deduction).

Does anyone pay for care of a child, disabled adult, or other dependent so you or the other person can go to work, school, or look for a job? ☐ Yes ☐ No If **yes**, please answer this question.
If **no**, skip to the next question.

Who gets care?	Who gives care? (name and address of provider)	Amount paid?	How Often Paid? (weekly/monthly, other)
		\$	
		\$	
		\$	
		\$	

Does anyone help your household pay all or part of your child/adult care costs listed above? ☐ Yes ☐ No If **yes**, complete below.

Who gets care?	Who helps pay?	Amount paid?	How Often Paid? (weekly/monthly, other)
		\$	
		\$	



12. Child Support Payments

Is anyone listed in question 6 legally obligated to pay child support, including back child support? ☐ Yes ☒ No
If **yes**, please answer this question.
If **no**, skip to the next question.

Who pays child support?	Name of child(ren) for whom child support is paid:	Amount paid?	How Often? (weekly/monthly, other)
		\$	
		\$	



13. Spousal Support/Alimony



Is anyone listed in question 6 legally obligated to pay spousal support/alimony? ☐ Yes ☒ No
If **yes**, please answer the questions below.
If **no**, skip to the next question.

Who pays spousal support/alimony?

Amount paid?

How often?
(weekly, bi-weekly, monthly, other)



14. Special Needs Expenses

Does anyone have a special medical condition or situation that requires any of the following?

Special diet prescribed by a doctor?

☐ Yes ☐ No

Other special need? (specify) ☐ Yes ☐ No

Special phone or other equipment?

☐ Yes ☐ No

Housework (no one in the home can do it)?

☐ Yes ☐ No

Please list the name of the person with the special need and explain:

Very high use of utilities?

☐ Yes ☐ No

Special laundry service?

☐ Yes ☐ No



15. Household Expenses

Does anyone you purchase and prepare food with get billed for any household expenses? ☐ Yes ☒ No

If **yes**, please answer this question.

If **no**, skip to the next question.

NOTE: Do not enter amounts paid by housing assistance such as HUD or Section 8. The heating and cooling, telephone, other utilities, and the homeless shelter are set allowances. It is not necessary to fill in the actual amount owed.

Type of Expenses	Have Expense?	Who Pays?	Amount Owed	How Often Billed? (weekly/monthly)
Rent or house payment	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Property taxes and insurance (if billed separate from rent or mortgage)	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Gas, electric, or other fuel used for heating or cooling, such as firewood or propane (if separate from rent or mortgage)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Telephone/cell phone	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Homeless Shelter Expense	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Water, sewage, garbage	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does anyone not in your household help you pay for the expenses listed above?		Who helps pay?	How much?	How often paid?
			\$	

☐ Yes ☐ No If **yes**, please complete.

Does your household get, or expect to get any payments from the
Low Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No

20. Is anyone getting In-Home Supportive Services (IHSS)? ☐ Yes ☒ No
If yes, fill in the information below.

WHO GETS SERVICES?

HOW MUCH DO YOU PAY EACH MONTH FOR THE SERVICES?

21. Does everyone listed in question 6 buy and prepare food with you? ☒ Yes ☐ No
If no, list the people who don't buy and prepare food with you.

NAME

NAME

NAME

NAME

21a. Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? ☐ Yes ☒ No If yes, who:

22. Answer these questions for anyone who needs health coverage. Is anyone enrolled in health coverage now from the following? ☐ Yes ☒ No
If yes, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

☐ Medicaid/Medi-Cal

☐ Employer Insurance

☐ CHIP

Name of health insurance

☐ Medicare

Policy number:

☐ TRICARE (Don't check if you have direct care or Line of Duty)

Is this COBRA coverage? ☐ Yes ☒ No

Is this a retiree health plan? ☐ Yes ☒ No

☐ VA health care programs

Is this a state employee benefit plan? ☐ Yes ☒ No

☐ Peace Corps

☐ Other

Name of health insurance

Policy Number:

Is this plan a limited-benefit plan like a school accident policy? ☐ Yes ☒ No

22a. Is anyone listed on this application offered health care coverage from a job? ☐ Yes ☒ No
If yes, you'll need to complete and include Appendix A.

22b. Is anyone's health insurance expected to end or has it ended in the last 90 days? ☐ Yes ☒ No
If yes, please answer the question. If no, skip to the next question.

Insurance Company

Person Insured

Expiration Date

Reason it ended or will end

22c. Does anyone want help for medical bills from the last three months? ☐ Yes ☒ No
If yes, who:

23. Does anyone listed in question 6 plan to file a federal income tax return next year? ☒ Yes ☐ No
If yes, complete the questions below for each tax filer.
If no, skip to 23f.

23a. Please complete this section for each person who plans to file a federal income tax return next year if you answered yes to question 23. You can still apply for health insurance even if you don't file a federal income tax return.

23b. Name of person planning to file a federal income tax return: James E. Norton

23c. Will this person file jointly with a spouse? ☐ Yes ☒ No

If yes, name of spouse:

23d. Will this person claim any dependents on their tax return: ☐ Yes ☒ No

If yes, please list the name(s) of the dependents you are claiming:


23e. How is the dependent(s) listed in 23d related to the tax filer who will claim them?: N/A

23f. To make it easier to determine my eligibility for paying health coverage in future years. I agree to allow you to use income data, including information from tax returns. You will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next (check one): ☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☒ No, don't use information from tax returns to renew my coverage.


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 Optional for health care; only answer if someone applying is 65 or older or disabled. If you are applying for cash aid, you must answer the question.

 **26. Vehicles**

Does anyone own, have the use of, or have their name on any registration of any motor vehicle, such as: a car, motorcycle, snowmobile, recreational vehicle (RV), or motorboat, etc., even if it isn't running? ☐ Yes ☒ No
If yes, please fill out the information in Appendix E.

 **27. Does anyone in question 6 own or are they buying a home, land, or property anywhere including in another state or country?** ☐ Yes ☒ No If yes, please explain.

 Optional for health care; only answer if someone applying is 65 or older or disabled.

Who owns or is buying the home/property?	Address of the home/property	Is someone renting the home from the owner?	How much rent does the owner get?	Not living in now but owner expects to move back into the home someday?
NA	NA	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	<input type="checkbox"/> Not rented <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	<input type="checkbox"/> Not rented <input type="checkbox"/> Yes <input type="checkbox"/> No

 **28. Diversion Program**

Has anyone received a Diversion cash payment or non-cash services from any county or other state? ☐ Yes ☒ No
If yes, please answer the question. If no, skip to the next question.

Name	County/State Received From	Amount Received	List of Services Received	Estimated Value of Services	Date Last Received
		\$		\$	

 **29. Duplicate Benefits**

Have you, or any member of your household been convicted of fraudulently receiving duplicate SNAP (federal name for food assistance program) benefits in any State after September 22, 1996? ☐ Yes ☒ No

If yes, who? _____

 **30. Trafficking Benefits**

Have you, or any member of your household, ever been convicted of trafficking (allowing use of or selling EBT cards to others) SNAP benefits of \$500 or more after September 22, 1996? ☐ Yes ☒ No

If yes, who? _____

 **31. Trading Benefits for Drugs**

Have you or any member of your household been found guilty of trading SNAP benefits for drugs after September 22, 1996? ☐ Yes ☒ No

If yes, who? _____

 **32. Trading Benefits for Firearms or Explosives**

Have you or any member of your household been found guilty of trading SNAP benefits for guns, ammunition or explosives after September 22, 1996? ☐ Yes ☒ No

If yes, who? _____

 **33. Fraud**

Have you or anyone in your household had their cash aid stopped for being found guilty of Welfare Fraud? ☐ Yes ☒ No

If yes, who? _____ When? _____

Where? _____

 **34. Non-Cooperation/Sanctions**

Have you or anyone in your household had their cash aid stopped for failure to cooperate with eligibility requirements, work/training sanctions or any other reason? ☐ Yes ☒ No

If yes, who? _____ When? _____

Where? _____ Why? _____

**35. Fleeing Felon**

Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody, or going to jail for a felony crime or attempted felony crime? ☐ Yes ☒ No

If **yes**, who?

**36. Probation/Parole Violation**

Have you or any member of your household been found by a court of law to be in violation of probation or parole? ☐ Yes ☒ No

If **yes**, who?

**37. Other Special Needs**

Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and/or unusual circumstances, such as a fire, earthquake, or flood? ☐ Yes ☒ No

If **yes**, please explain:

**38. Other Services**

The following services are available. Your answers to the questions will not affect your eligibility.

A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.

- Do you want more information about CHDP services?
- Do you want CHDP medical services?
- Do you want CHDP dental services?
- Do you need help making appointments or with transportation to CHDP services?

☐ Yes ☒ No
☐ Yes ☒ No
☒ Yes ☐ No
☐ Yes ☒ No

B. Do you want more information about immunization services?

☒ Yes ☐ No

C. If you are pregnant, you can get help finding a doctor, getting healthy foods and other help. Do you want to talk to someone about this help?

☐ Yes ☒ No

D. Are you breastfeeding a child?

If **yes**, have you given birth within the last 12 months?

If you checked yes to 38 C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).

☐ Yes ☒ No
☐ Yes ☒ No

E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unwanted pregnancies and/or have the next child?

If **yes**, call your health care plan or regular doctor. Or, for facts and the location of confidential family-planning clinics, call toll-free 1-800-942-1054.

☐ Yes ☒ No

**39. Third Party Liability**

Is anyone who is applying for healthcare involved in a worker's compensation claim, lawsuit, or settlement because of an accident or injury?

If **yes**, please tell us who:

☐ Yes ☒ No

Additional Writing Space